Three Sisters Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This announced comprehensive inspection was conducted on 28 and 29 November 2017. The provider was given 48 hours' notice of our intention to carry out this inspection. This is because key personnel are sometimes out of the office visiting people who use the service and we needed to ensure that representatives from the management team were available to participate in the inspection. Following the first two days of the inspection, we advised the registered manager of our plan to return to the service on 14 December 2017 to gather additional information and provide feedback. We continued to speak with people who use the service until 21 December 2017.

At the previous comprehensive inspection on 22 June 2016 breaches of legal requirements had been found, which included safe management of medicines and support of staff, in regards to staff supervision and training. The service was rated overall as Requires Improvement. Following the inspection, the provider had written to us to state what actions they would take in order to meet the legal requirements in relation to the breaches.

We had subsequently carried out a focused inspection on 14 February 2017 to check the provider had followed their plan and to confirm that they had met legal requirements. We had found that although some improvements had been achieved, the provider had not satisfactorily met the breaches for safe management of medicines and support of staff. It had been noted that although staff were now in receipt of appropriate supervision, there were shortfalls in terms of staff receiving suitable training to meet people's needs. We had issued two Warning Notices for the two breaches of legal requirements and had received an action plan from the provider to explain how they would address the issues within the Warning Notices.

A focused inspection was undertaken on 25 April and 15 May 2017 to check that the provider had adhered to their action plan and to establish if they now met legal requirements. We had found that the provider had achieved the required improvements and concluded that the legal requirements had been met.

Three Sisters Care Ltd is a domiciliary care agency, which provides a personal care service to older adults and younger adults, including people living with dementia and people with a physical disability, learning disability and/or sensory impairment living in their own homes. Most of the people who use the service live in the London Borough of Tower Hamlet, and other people reside in nearby boroughs including Haringey, Islington, Hackney, and Barking and Dagenham. The registered manager informed us that the majority of the 140 people using the service at the time of the inspection received the regulated activity of 'personal care'. The Care Quality Commission only inspects the service being received by people provided with 'personal care'; for example, care and support with maintaining personal hygiene, continence, moving and positioning, and eating and drinking.

There was a registered manager in post at the time of our inspection, who was present on each day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal

responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager contacted us and local stakeholders shortly before the final day of this inspection to inform us that she had submitted her resignation to the provider.

We found that the provider's recruitment practices did not always show that all the required checks were in place to ensure that people were supported by suitable staff.

People expressed that they were happy with how they were assisted with their medicines. The provider carried out monthly audits to protect people from the risk of unsafe medicine practices; however, staff needed better defined guidance about how to support people with their medicines.

Risk assessments had been developed to identify and mitigate risks to people's safety and wellbeing. However, these assessments needed a more detailed approach to address people's individual needs, for example guidance for staff about how to support people with behaviours that challenged.

Staff understood how to protect people from the risk of abuse and the provider reported any concerns to the appropriate authorities. They were given safeguarding training and written information about how to whistle blow.

Some care files clearly demonstrated that people were able to make their own decisions and other care files stated that a relative held the legal authority to make these decisions. However, we saw that some people's files did not demonstrate that the provider consistently worked in line with the Mental Capacity Act 2005, as care staff did not have clear information as to whether relatives or other individuals had the legal authority to make decisions about people's care.

People who use the service and their relatives commented favourably about the skills and approach of their care workers. Staff were supported with training, supervision and group meetings; however the frequency of supervisions and appraisals were not being delivered in accordance with the provider's own policy for staff development.

Where people were being supported to meet their nutritional needs, staff provided support that met their individual wishes, dietary requirements and cultural needs. Staff understood how to support people to meet their health care needs, for example one person told us that their care worker assisted them every morning to apply prescribed stockings to reduce the complications of poor circulation.

People using the service spoke positively about the caring and pleasant attitude of care staff, and their willingness to make sure that people received a good standard of care. Care staff knew how to meet people's needs in a respectful manner that upheld people's dignity and self-esteem.

The provider enabled people to receive care and support in a way that suited them and met their choices.

We found examples where people had started receiving care and support before the provider had drawn up a care plan that reflected their wishes and their assessed needs. This meant that staff did not always have a formally written plan to follow to ensure people's various needs were addressed.

People and their relatives were provided with information about how to make a complaint. The complaints log showed that complaints and concerns were responded to, apart from one complaint we looked at. The provider had also received compliments from people and their representatives.

People were positive about the quality of care and support to meet their health care needs and were pleased with how the service was managed.

Although positive achievements were demonstrated such as the high level of satisfaction by people and relatives, the provider needed to address shortfalls in the quality of the service. This included the need to ensure that prompt care planning was in place and improvements to staff support, medicines guidance and risk assessments.

There were systems in place to monitor the quality of the service. This included feedback from people who use the service, their relatives and other stakeholders. We had received information of concern from anonymous sources prior to the inspection. We also identified certain broad themes that were brought to our attention by the anonymous source. For example, the busy atmosphere at the main office and how it could impact on individual staff who need a quiet environment to discuss any concerns.

The provider appropriately informed the Care Quality Commission of notifiable incidents, as required by law.

There is a recommendation for the provider to improve the scrutiny for ensuring all recruitment files demonstrate safe recruitment. We have issued two breaches of regulations. The first is in regards to the lack of information within people's care files to confirm the details of the individual who holds legal authority to make decisions about their care and the second is in relation to the need for the provider to ensure that all persons receiving care and support have an individual care plan produced when they begin using the service.

You can see what action we told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The recruitment practices did not consistently demonstrate that checks were in place to ensure that people were supported by suitable staff.

Medicine audits were undertaken to protect people from the risk of unsafe medicine practices; however, staff needed clearer guidance about how to support people with their medicines.

Risk assessments had been developed to identify and mitigate risks to people's safety and wellbeing but required a more detailed approach to address people's individual needs.

Staff understood how to protect people from the risk of abuse and the provider reported any concerns to the appropriate authorities.

Is the service effective?

Requires Improvement

The service was not always effective.

People's files did not demonstrate that the provider consistently worked in line with the Mental Capacity Act 2005, as care staff did not have clear information as to whether relatives or other individuals had the legal authority to make decisions about people's care.

Staff were supported with training, supervision and group meetings; however the frequency of supervisions and appraisals were not being delivered in accordance with the provider's own policy for staff development.

Where people were being supported to meet their nutritional needs, staff provided support that met their individual wishes, dietary requirements and cultural needs.

People were positive about the quality of care and support to meet their health care needs.

Is the service caring?

Good

The service was caring.

People using the service spoke positively about the kindness of their care workers.

Care staff understood how to meet people's needs in a respectful manner that promoted their dignity and confidentiality.

The provider enabled people to receive care and support in a way that suited them and met their choice.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider had not consistently ensured that staff had written information about how to meet people's needs when people commenced using the service.

People were provided with information about how to make a complaint and complaints were appropriately responded to, apart from one complaint we looked at.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People using the service and their relatives were happy with how the service was operated.

Although positive achievements were demonstrated such as the high level of satisfaction by people and relatives, the provider needed to address shortfalls in the quality of the service.

There were systems in place to monitor the quality of the service.

The provider appropriately informed the Care Quality Commission of notifiable incidents.

Three Sisters Care Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This announced inspection was conducted on 28 and 29 November and 14 December 2017. The provider was given 48 hours' notice because we needed to make sure that somebody would be available to assist us with the inspection.

The inspection team consisted of two adult social care inspectors and two experts by experience. The two inspectors visited the office location and the experts by experience contacted people during the inspection to find out their views about the quality of care and support they received from the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Both experts by experience had personal experience of caring for family members and friends who use domiciliary care services.

Prior to the inspection we looked at the information that the Care Quality Commission (CQC) held about the service, which included the previous inspection report, notifications of significant incidents reported to the CQC by the provider and other information we had received from anonymous sources. We informed the designated contracts monitoring officer for this service at the London Borough of Tower Hamlets that we intended to carry out this inspection. The contracts monitoring officer sent us their current monitoring information in relation to the service, which included quality surveys undertaken with people who use the service.

We spoke by telephone with 16 people using the service and the relatives of another eight people. During the inspection visits to the office location we spoke with two care coordinators (also two of the three directors of the organisation), the deputy manager, two administrators, the registered manager, the chief executive (the third director) and one care worker. We looked at 16 people's care plans, 10 staff recruitment files, staff training and supervision documents, medicine administration records, a range of policies and procedures, and various quality assurance audits in regards to the running of the service. In total we spoke

with 10 care workers before and after the visits to the service.

Requires Improvement

Is the service safe?

Our findings

The registered manager informed us that the service had recruited new staff since the previous inspection and other new staff had transferred to the organisation through TUPE arrangements. Transfer of Undertakings (Protection of Employment) Regulations is when employees move from their former employer to their new employer by operation of law. The staff recruitment folders demonstrated that the provider had not reliably maintained the safe recruitment practices that we had noted at the focused inspection in February 2017. For example, we found that some recruitment files did not demonstrate that references had been verified and one file contained only one reference. The provider's recruitment policy stated that new staff were subject to a review six months after they commenced employment but we did not find evidence of this.

We discussed these findings with the registered manager, who acknowledged that discrepancies in the recruitment process had occurred due to the high level of staff recruitment within the past year. The registered manager stated that a schedule had been developed to check recruitment files in order to identify and address any inconsistencies. The provider informed us that some of the staff had transferred from other organisations where there had been a reluctance to release documentation. This had created additional work for the office staff team as they had to pursue the necessary paperwork.

We recommend the provider seeks guidance from a reputable source in order to implement more rigorous systems for documenting the recruitment of staff and monitoring the quality of recruitment files.

People using the service and their relatives told us that staff were punctual and reliable. People stated, "They (care workers) come four times a day and they always turn up on time", "They come four times a day and they always arrive on time except at weekends. It's usually due to transport connections and they always apologise. They've never missed an appointment, but we do have a number to ring if we ever need to" and "They are not too bad with their timekeeping except at weekends when they are sometimes late due to transport and some do let us know if they're running late but not all. We've only been using the service for two months but so far they've always found cover if someone hasn't turned up for work or has rung in sick." There were no concerns expressed about punctuality and reliability of staff where people needed care and support from two care workers at the same visit.

However, we received varied views when we spoke with people in regards to whether they received a consistently delivered service from care workers that they were accustomed to. Comments from people included, "Now I have one regular carer", "Two regular care workers, had different ones when I first started", "I have had different ones and they have always been very helpful", "Lots of different carer workers, I wish I have the same carer workers. One day I have three care workers in a day, other times I get the same one all day, it is always changing" and "I have two regular care workers and they're always more or less on time depending on traffic and buses. They've never missed me out." Relatives told us, "Yes, [he/she] still has the two same care workers who came from the previous agency", "We had one regular care worker and then [he/ she] got a new care worker" and "When a regular care worker was on holiday, we had three different care workers. The care worker has told me that [he/she] isn't coming on [specific days of the week] and

another care worker is coming. The office hasn't rung to tell us."

Care workers told us that they had sufficient time to travel to people's homes and were usually able to spend the agreed scheduled length of time at each visit. We were informed by the registered manager that an 'Electric Call Monitoring' (ECM) system was in the process of being introduced by the local authority, as it was part of the contract requirement. At the time of the inspection 60% of staff were using ECM and the aim was for 100% compliance by the end of 2017. The provider informed us that they had not been able to achieve 100% compliance at the time of the inspection as some staff were experiencing technical difficulties with the system. We did not check the data gathered by ECM at this inspection as the system was not fully functional, therefore we will review how the provider uses the system to improve the quality of its service to people at the next inspection. There was a 'failed visits' policy in place which stated that a care worker needed to inform their line manager within 15 minutes of being unable to make contact with the person using the service. The line manager was then required to follow a process of contacting different parties, for example the person's neighbour or other local key holder. We found that the provider did not always complete the required written report following a failed visit and the line manager's adherence with the stipulated instructions to contact different parties was not always documented on the report.

People who use the service and their relatives told us they were happy with how their care workers supported them to take their prescribed medicines. Comments from people included, "They (care workers) help. I will send [him/her] to the chemist to get my medicine. I am happy with how they help me", "The carers get them out of the box and put them on the table and watch me take them. It is okay" and "They give it to me in a little pot, give me some water and I take it." Relatives informed us, "They (care workers) give [him/her] [his/her] medicine, happy with this" and "They (care workers) give medicine, except for [specific medicine with varying dosages] which the family do…we are happy with this support."

The provider demonstrated that systems were in place to monitor that people were safely supported with their medicines. We looked at the medicines audits for a period of seven months since the previous inspection. The audits demonstrated that any issues or concerns were recognised and necessary actions were taken. For example, the registered manager spoke with care workers if they were not correctly completing the medicine administration record (MAR) chart or did not inform their line manager if there was a change in a person's medicines regime. It was noted that one particular concern had resulted in disciplinary action for the care worker. We also found that there were omissions on a MAR chart which had not been addressed by the provider. This appeared to be due to a person sometimes receiving medicines support from their care workers and at other times from their relatives.

We observed that people's care and support plans sometimes contained conflicting descriptions in regards to how care workers should support people with their medicines, for example one care and support plan and accompanying medicines risk assessment stated that the person needed prompting. However, the daily records written by care staff stated that they had given or administered the person's medicines, which meant that people's records did not always accurately reflect the level of support and care they received. We discussed this finding with the registered manager and one of the care coordinators, so that this could be checked and rectified via the provider's medicines audits and through speaking with staff at one to one supervision and staff meetings. The management team acknowledged that the different terminology still caused some confusion for some care workers.

Following the inspection visit, we received information from the provider. The provider stated that they conducted weekly audits of MAR sheets and spot checks were carried out on a regular basis by field supervisors, and any queries or issues arising from the audits or checks were promptly dealt with. We were informed that all staff have medicines training before they can administer medicines. Two types of

medicines training was delivered; all staff attended a module called 'Medication Awareness' regardless of whether they were administering medicines. This training was provided so that staff who were not administering medicines had the necessary knowledge to spot if a service user may not be self administering correctly and therefore flag this to the office team. All staff who were considered to possess the necessary skills and experience had to pass an "Administering Medication" course and were observed at people's home by field supervisory staff before being signed off as competent to administer medicine. The provider stated that discussions have taken place about medicine practices at staff meetings, supervisions and training sessions; care workers have been told to record if the person using the service has self-administered or was supported by a relative.

People who use the service and relatives told us they felt safe using the service. Comments included, "I trust the carer I have", "(My family member) is safe…two very nice ladies (care workers), "I am safe, I always feel better when someone is here", "I am safe, they (care workers) are very ordinary nice women who like to please", "I do feel safe. (Care worker) makes sure I am safe when I get in and out of the shower" and "Absolutely 100% safe, they (care workers) are very concerned and very helpful."

People using the service were protected against the risk of abuse or discrimination because staff had been provided with training and guidance about the actions to take if they thought a person was at risk. Care workers told us they would report any concerns to their line manager and they were aware of how to escalate their concerns within their organisation and/or externally, if they believed that their line manager had not taken appropriate steps to protect a person. Records showed that staff had received safeguarding training and the minutes of staff meetings demonstrated that care workers and other staff were reminded of their responsibilities to protect people using the service.

We looked through the safeguarding concerns which had arisen since the previous inspection. We noted that in some circumstances the provider had raised concerns about people's safety because of information that care workers had reported back to their line managers. For example, concerns that a person using the service was at risk of financial abuse by an external individual who had befriended them or by a relative who had informally taken day to day control of their finances. This showed that care workers were vigilant and had developed relationships of trust which enabled people to disclose their concerns. Where safeguarding alerts had been raised by health and social care professionals, we saw that the registered manager had taken a thorough approach to ensuring that improvements were made to people's care and support in order to promote their safety and wellbeing. For example, we noted that a health care professional had raised concerns about how staff supported a person. The registered manager had liaised with the professional and fully implemented the required improvements. The professional wrote to the provider to comment on the improvements attained and compliment staff on the positive changes they had achieved for the person using the service.

Systems were in place to appropriately manage the risks to people's safety; however, we noted that some improvements were needed to ensure that people's risk assessments accurately reflected their current needs. The care and support plans we looked at contained individual risk assessments which addressed their health and social care needs, for example moving and positioning, personal care and risk of developing pressure ulcers. The environmental risk assessments established whether there were any concerns at people's homes, for example trip hazards caused by loose rugs or cluttered floors. People using the service, and their relatives where applicable, were provided with general advice about how to minimise identified risks and referred to external professionals such as occupational therapists and physiotherapists if the nature of the risks meant that specific professional input and guidance was required. During the inspection the registered manager produced a revised template to ensure that risk assessments captured the information needed to produce thorough risk management guidelines.

We noted from looking at the daily records within the care and support plan that one person using the service presented with behaviours that challenged, but the provider had not developed a risk assessment and risk management plan to address these needs. The registered manager was able to demonstrate that she had contacted the person's community specialist nurse and had arranged for care workers to attend bespoke training from the health care professional. The risk assessment for another person using the service also stated that a person had behaviours that challenge but there was no written guidance for staff about how to support the person when they displayed specific behaviours. We also noted that a medicines risk assessment had not been updated following an incident.

People who use the service were protected from the risk of infection because suitable arrangements were in place to promote safe infection control practices. People told us, "They (care workers) do their job properly and put on their gloves and aprons", "(Care worker) does wear gloves and aprons when [he/she] is helping me" and "Yes, they (care workers) are very hygienic." A relative informed us, "They (care workers) give (my family member) a full body wash, they have a box of gloves and aprons."

Care workers told us they had received training in regards to infection control, food hygiene, and health and safety. Prior to the inspection we received information from an anonymous source which alleged that care workers were not always able to access the personal protective equipment (PPE) they required such as disposable gloves and aprons. However the care workers we spoke with stated they were provided with sufficient PPE.

The registered manager demonstrated that she analysed the outcomes from safeguarding investigations, accidents and incidents in order to improve how the service safely met the needs of people who use the service. We noted that the registered manager had carried out joint visits with external health and social care professionals to people's homes when there had been concerns about their safety and wellbeing, so that she could share the learning from these visits with the staff team. We viewed the accidents and incidents folder for 2017 and saw that all of the reports had been appropriately followed through and actioned where necessary, for example notifications had been sent to social services and the Care Quality Commission.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

During our discussions with the registered manager and other members of the management team, it was clear that they understood that only relatives or other individuals with an appropriate Lasting Power of Attorney (LPA) or other recognised legal authority were permitted to sign care plans on behalf of people using the service. We saw that where people were noted to have capacity to make decisions about their care, they had been asked to sign their care plan. Other care plans recorded that LPA's were in place but did not consistently state whether the LPA had been viewed by a representative from the agency. One person's care plan had been signed by a relative and there was no information recorded to indicate that the relative had the legal authority to do so, or that there had been a best interests meeting to discuss how to meet the person's health and social care needs. The absence of this information meant that the provider could not be assured that they were liaising with the correct individual who had legal authority to make decisions and therefore people's rights may not have been protected. We brought this to the attention of the registered manager during the inspection and she revised the care planning documentation so that staff were prompted to ensure that this information was gathered.

This constitutes a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that their care workers spoke with them in a respectful manner and always sought their consent before providing personal care and other support. Comments from people included, "They always ask permission and ask if I need anything else", "They ask me and they do what I ask them to do" and "They always ask me if there is anything in particular I want done. They don't come in and start doing things." A relative stated that the care workers checked each day if their family member felt ready for their meal. Care workers explained to us that the importance of seeking people's consent was discussed during their training, supervision and 'spot check' visits. One care worker told us that the person they looked after had cognitive impairment, so it was vital to explain what kind of assistance they wished to offer at each visit to enable the person to feel reassured.

People using the service and their relatives were predominantly positive about the skills, knowledge and approach shown by their care workers. Comments from people included, "They (care workers) roll up their sleeves, put their gloves on and get on with their work, they do it properly", "They are professional" , "They have a good attitude, are professional and very caring" and "Yes, [he/she] is very efficient and [he/she] is quality." Relatives stated, "Yes, (care worker) knows what [he/she] is doing", "They are trained and skilled" and "They are able to do what is on our spec."

However, some people using the service and their relatives expressed mixed views about how new staff were supported to understand their responsibilities. One relative said "Our previous provider withdrew from the contract within the last year and Three Sisters took over [my family member's] care. It's been okay so far and we have some of the previous care workers from the prior company, so we have some partial continuity. If they do send new care workers they always send them with a regular care worker as they are double-up appointments, so the regular care workers can tell them what to do." Other comments included, "Yes, one (care worker) came to shadow", "The new care worker came on [his/her] own" and "Never had anyone shadow. If someone is new they don't really know the routine. They go through the book and the family tell them what to do." We noted that some of the recruitment files we looked at did not evidence that new staff had completed an induction and/or shadowing experience, although the care workers we spoke with were complimentary about how the provider supported them when they began working for the organisation.

The care workers we spoke with said that they were happy with the quality and scope of training they received. The staff we spoke with included employees who had transferred to the service from other organisations within the past 12 months. One care worker informed us that they had transferred to the provider very recently and had been given a list of the training they needed to do, with some of the training scheduled to take place imminently. Records showed that staff undertook training in a range of topics, which included safeguarding vulnerable adults, first aid, moving and positioning, medicines, infection control, and health and safety. Staff were supported to undertake the Care Certificate, which is an identified set of standards that health and social care workers adhere to in their daily working life and provides introductory skills and knowledge to provide a good standard of care and support.

The supervision records showed that some staff received up to four supervision sessions each year, and others received less. These sessions were delivered as one to one supervisions and observations of their practice, followed by a discussion. We noted that the quality of staff supervision was variable, which was discussed with the registered manager. We were informed that some supervisory staff were more experienced than others and the provider was aware of the need to support new supervisory staff to develop their leadership and supervisory skills. We were aware that a significant number of staff would not yet have had an appraisal because they had transferred from another provider and we noted that the provider's own external audit of its compliance identified that the management team was behind with carrying out staff appraisals.

People told us they received the support they needed where they had been assessed as requiring encouragement and/or assistance with meeting their nutritional and hydration needs. Comments from people who use the service included, "They (care workers) help me get up, have a wash, make my meals and put me to bed. To be honest I don't care what I eat as long as I eat something, but they always ask me what I want", "Yes definitely, they give me a choice of meals, [care worker] makes everything look nice on the plate" and "I have ready meals. I have the stuff in for them (care workers) and they prepare it. They do this well." Relatives said, "They (care workers) cut [his/her] food up for [him/her] sometimes. The carer will offer to help [him/her] eat it" and "The carer will let us know if there is a problem … [he/she] let me know that the meals on wheels had not arrived."

The care plans we looked at had clear information about people's dietary needs as well as their known allergies, likes and dislikes, so that people using the service could receive individual care and support with eating and drinking. We noticed that one person told their care workers that they wanted to try different flavours of their prescribed dietary supplement drinks to prevent boredom with their diet. The provider informed the person's allocated dietitian, having gained the consent of the person to do so. This showed a committed approach to supporting people to meet their nutritional and health care needs. At the time of the inspection the provider was not supporting people to receive their nutrition through enteral feeding

tubes.

People who used the service spoke positively about the support they were given by staff if they had any concerns about their health. Comments included, "They (care workers) ask me if I have rung the GP if I am in pain" and "Yes, they take me to the swimming baths as I do exercises for my knees." Relatives told us, "The carer will ring if there is a problem, they will let us know…and won't leave [him/her] if [he/she] is distressed", "There was a meeting with the physiotherapist and the care worker. There are a list of exercises for [my family member]", "[My family member] has [complex health and personal care needs], so they (care workers) come four times a day. [Care worker] is excellent and trains the less experienced ones" and "When [my family member] has a cough, the carer will let me know." One relative told us that their family member had recently been recommended by their GP to drink hot water, lemon and honey at regular intervals as they had a cold. The relatives told the person's care worker and they supported this regime.

The registered manager informed us that she had prior professional experience of working as a registered nurse and had previously managed other types of health and social care services. We noted from people's care files that she liaised well with external professionals and appropriately referred people to relevant services, for example district nurses, occupational therapists, community psychiatric nurses and social workers. Through looking at one person's care file, we saw that concerns had been identified by a health care professional as the person had complex needs and did not wish to accept elements of their agreed care package. The registered manager had visited them at home and worked in partnership with other services so that the person's health care needs and safety were addressed. Care workers demonstrated an awareness of the actions to take if they were concerned about a person's health and wellbeing. The care workers we spoke with told us they would contact their line manager for advice if they noticed a deterioration in a person's mobility and/or observed that there were changes with other activities of daily life, for example if a person appeared disorientated. Staff had received training in first aid and basic life support and confirmed that they would call for an ambulance if a person needed urgent medical assistance.

Good

Is the service caring?

Our findings

We received many positive views from people using the service and relatives about the kind and compassionate approach of the care workers and other staff they met, for example members of the supervisory and management team. Comments included, "I have a regular carer and she's a lovely lady", "I'm certainly satisfied with my regular carer. [He/she] is very polite and helpful", "They (care workers) are very respectful towards me (during delivery of personal care)" and "My carers are very nice, really lovely girls…very friendly and both are busy little bees." One person informed us that their care workers went the "extra mile" and assisted them with occasional extra tasks, "They are excellent. I have had some very nice girls who come, sometimes if I have wanted some things from the shop or ironing they are willing always and ready to help." One person told us about an occasion when they felt frail due to their health care needs and did not think that their care worker demonstrated empathy and kindness. This finding was discussed with the provider and we were satisfied with the actions they proposed to take.

Relatives told us, "[My family member]…they give [him/her] a shower and they're always very respectful towards [him/her] when doing [his/her] personal care" and "The carers are very good, nice chaps and they're always very respectful towards [my family member] and me too. We're very lucky and they're so good with him."

The care workers we spoke with demonstrated that they had built up good relationships with the people they supported and had got to know them, for example the topics they liked to talk about, their cultural practices and the family relationships that were important to them. However, we did not find that people's care plans contained this information although there was a section to record people's life histories and current or former hobbies. This meant that where people were not able to talk about their backgrounds and interests due to their health care needs and they lived alone, new care workers would not readily have the information they needed to engage with people and develop a meaningful rapport.

We noted from people's care plans that the contact details of relatives or friends had been recorded and some people had expressed that they wished for their relative or friend to contribute to the planning and reviewing of their care. Other care plans showed that people lived with a relative and the assessment process demonstrated that the person wished for their relative to be consulted as well. The registered manager told us that she had information about local advocacy services to share with people if they wanted to have independent support to make their opinions known and/or to support them to make a complaint. Advocates support people to express their views and wishes.

People using the service told us that their care workers understood their entitlement to be treated with dignity and respect. Comments included, "Their (care workers) behaviour is very good", "They never take liberties and they always ask when they want to get something from the cupboard, they don't go looking" and "I tell them I don't want them to go into my bedroom as this is where I pray and they respect this." People confirmed that their care workers supported them to be as independent as possible, in line with people's own wishes, "They realise that I like to do things for myself but if they see me struggling they will help" and "I tell them to leave the shopping in the basket so I can deal with it myself, and they respect this."

People and relatives confirmed that the provider sent them a care worker of the same gender for personal care, if they had stated that this was required.

The care workers we spoke with demonstrated a positive understanding of how to support people in a dignified way and how to promote their rights to confidentiality and privacy. They told us that they always checked that people were not unnecessarily exposed when being supported with personal care, for example through ensuring that people had bathrobes and towels close at hand when having a shower or bath and making sure that doors, windows and curtains were closed.
Care workers understood the importance of not speaking about people in an indiscrete manner if they needed to telephone their line manager when out in the community and their training addressed the need to only share information with external parties involved in people's care, for example people's social workers and district nurses.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people and their relatives in regards to whether they felt they had been involved in the development and subsequent reviewing of their care plan. Some people told us they had not been using the service for long enough to be able to comment on the frequency of reviews. People stated about their care plans, "There is one here but no review" and "The care plan is in the kitchen, not sure about a review." Relatives commented, "We have a file, nobody has come to see us to review", "The manager came when the service changed over to Three Sisters and we set up the care plan, they haven't been back since" and "The lady came in when Three Sisters took over, checked everything was there and asked us questions. I have also been rung by the service to ask how things are. We had a review a few months ago and they like to speak with [my family member] as well about what is going on."

The care plans we looked at showed that people's needs were assessed when they began using the service and the assessment tool was used to develop an individual care plan, although this was not always the case. We noted that one person who used the service did not have a care plan in place for 20 days following their transfer from another agency. We discussed this finding with the deputy manager who informed us that there had been a backlog in setting up new care plans and the staff had provided care for the person by following the information in the social services assessment. The person had a health care condition (epilepsy) and had seizures, however we could not find any written information for staff in terms of the signs they should observe for to indicate that the person was at risk of imminently having a seizure. There was no guidance about how care workers should respond in the event of a seizure. We looked at the daily records for this person with the registered manager as the entries by the care workers were at times illegible and too brief to demonstrate how the person had been supported.

A second care plan was dated five months after the person had commenced using the service and the guidance to support the person with a specific mental health problem lacked sufficient detail. It was not clear to us how the person's care workers were being advised to assist a person with complex needs.

A third care plan contained conflicting information as it stated that a person needed assistance with personal care in the morning but also stated that the person's family provided personal care in the morning. We could not establish the role and responsibilities of the care worker and the daily records were not available for us to check in order to gain clarification. A third care plan contained appropriate information to support staff to understand one of the person's health care needs, however there was conflicting information about how to support the person with a specific type of catheter. The daily records to accompany the third care plan were clear and legible.

This constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw examples of where people's care plans were responsive to their individual needs. For example, one person stated in their assessment that they wanted a Guajarati speaking female care worker and this need was met. Another person informed the provider that they were satisfied with their care during the week but

requested that the weekend care workers were changed as they were not following the agreed care plan. The registered manager met with the person and implemented their requested change. We also saw where care workers reported their concerns about the safety and wellbeing of a person to the management team. As a result of this information the registered manager contacted the person's local authority and asked for the person's needs to be assessed again, with a view to them receiving a larger care package that would mitigate identified risks to their safety and enable them to achieve a better quality of life within their home environment.

People using the service and their relatives were provided with accessible information to enable them to make a complaint. We noted that the service also received compliments too, including one from a local health care professional. Comments from people included, "They (management team and office staff) are quite amenable", "I've no concerns at the moment since they sorted out a regular carer for me", "They don't ring you, this company writes to you. The carers tell people in the office they are going to be late, the office don't phone the clients" and "I have the contact numbers for the office if I needed to complain but everything is absolutely fine. It's a very good service."

Relatives informed us, "The only issues I have are that there is no direct point of contact. There is only one phone number, so you can speak to anyone, there's no specific named contact. Also if there is a change of care they never inform you of the change", "I would ring the office, not needed to do so. There is a big file with the telephone number" and "Sometimes they (care workers) are not on time. They don't let me know if they are going to be late. Three Sisters missed calls twice, they didn't know the carer was off, they apologised." One of the relatives we spoke with informed us that they had made a complaint and was satisfied with the provider's response.

We viewed the complaints for 2017. Records evidenced that complaints had been responded to in a timely and professional manner. However, we were aware of one complaint that was not dealt with in line with the provider's complaints policy and procedure. Prior to the inspection we were contacted by the relative of a person who used the service, who was concerned in regards to the conduct of a member of the management team and how this impacted on their family. The relative sent us a copy of the email they had sent to the three directors. This complainant asked for an acknowledgement of the email and did not get a response to their complaint.

Requires Improvement

Is the service well-led?

Our findings

We spoke with people and relatives regarding their views about whether the service was well managed. People using the service told us, "I think it is well set up", "I am happy with the service. I've never had any dealings with the office staff apart from my initial meeting which was less than one year ago. I've never been asked for feedback, as far as I can remember", "My care workers are alright, but I rang to speak to the office last week and [he/she] was so rude and aggressive on the phone. The manager was out so I reported it to my care worker. I am going to complain" and "A very nice lady came out from the office and we filled a form out together. She was just checking how things were." Relatives commented, "They (office staff) have been out to do a review of [his/her] care package due to a change in [family member's] needs" and "I think the communication from the office could be better, particularly when they have to change the carer."

Overall, we found that people and relatives were mainly positive about how the service operated and in particular care workers were complimented for their pleasant and efficient approach, "They do what I want them to do, my carers are nice" and "The carers certainly know their job…I am very happy and it makes a world of difference to my life." People and relatives thought that improvements could be made in relation to the quality of communication from the office and we also received comments that a few people found communication difficult with their care worker if their care worker did not speak English as their first language.

The provider had a clear vision about how they wanted the organisation to develop and their values underpinned how the service was operated. We were informed that Three Sisters was established by three family members who wanted to create a domiciliary care agency that met the needs of the local East London community that they grew up in and continued to live in. The organisation viewed itself as a social enterprise which enabled suitable local residents to gain employment, develop their skills and confidence, obtain training opportunities and develop their careers if they wished to.

We noted that the service was undergoing significant changes at the time of the inspection. The registered manager had tendered her resignation and the chief executive officer informed us that they were stepping down from their role due to personal reasons, although they planned to maintain a part-time operational role within the organisation. We were informed that a new chief executive officer had been appointed and was due to commence their role in January 2018. Their responsibilities included acting as a line manager for the new manager when they were recruited. The registered manager told us that interviews were taking place in December 2017 to appoint a manager. The registered manager acknowledged that the growth in the size of the service had impacted on the stability of the service. We saw some innovative and detailed examples of how the registered manager had enabled staff to support some people with complex needs; however the scope of the work and the acute demands of expanding the service had meant that there was a limit to what the registered manager could realistically achieve.

There were systems in place to monitor the quality of the service, which included the audits for medicine administration record (MAR) charts, and the checking of the daily records in order for the management team to determine if people who use the service had safely received the care and support they needed in line with

their care and support plans. However, our findings showed that the provider was experiencing difficulties with ensuring that people had individual care and support plans in place at the time their care packages commenced with the organisation. We also found that more detailed information was needed in some of the care and support plans we looked at, so that care workers and supervisory staff had the applicable information to provide safe and appropriate care.

There were systems to seek the views of people and their relatives about the quality of the service. Although some people reported to us that they had not yet had a review of their care package since their initial meeting with Three Sisters when they transferred from another agency, we did find evidence that telephone quality monitoring had taken place, along with 'spot checks' by the field supervisors. The chief executive officer provided us with a copy of a compliance audit that was undertaken in November 2017 by an external health and social care consultant. This exercise had identified that some of the policies and procedures needed to be updated in order to reflect current legislation and guidelines. There were other suggestions for how to improve the service and the chief executive officer told us the management team planned to make these improvements.

The provider was able to gather views from external organisations in regards to the quality of the service, for example the local authority contracts monitoring team carried out checks. We looked at information gathered by this team in September and October 2107, which showed that people had a positive experience of using the service. In one of the surveys undertaken by the contracts monitoring team, we noted that 36 out of 37 people stated that they were satisfied with the quality of the service and felt that they could speak with their care workers about how they wished their care to be delivered. In regards to whether people encountered any difficulties communicating with their care workers, 42 out of 43 people stated that they had no concerns. About one third of people stated that their care workers did not always stay the required length of the visit; however the surveys for both months showed that people were reassured by the quality of their care and support.

Prior to the inspection we received anonymous information about how the service operated. Where the concerns have been about issues such as staff recruitment, training and supervision, we referred these issues to the registered manager so that they could complete an investigation within an agreed timescale. Where the anonymous concerns identified individual people who were alleged to experience deficits in the quality of their service and/or were at risk of neglect, this was brought to the attention of the local authority so that these concerns could be urgently investigated.

We received anonymous information of concern about the culture of the organisation, for example we were informed that the main office was loud which meant that care staff could not hear the advice given by their line manager if they telephoned for guidance about how to support a person. The registered manager acknowledged that the main office did get busy, although there were two smaller private offices that could be used as necessary. The registered manager implemented a system to reduce the number of visitors to the office by through introducing specific days that care workers could bring in time sheets and speak with their line managers about general issues related to their employment. However, care staff were advised that they could contact their line manager, visit the office and telephone the on-call manager if they needed advice about a person using the service or had a more immediate personal issue to discuss. Following this change, we received anonymous information to state that care staff were being restricted from seeking support from their line managers.

During the inspection we observed that the main office was a loud and busy working environment. This was also commented on by the relative of a person who uses the service who told us that they called in without an appointment. Office staff had welcomed them, offered a seat and made them a hot drink, but they had to

wait until the manager or a coordinator was free to speak with them. Other aspects of the anonymously received information did reflect areas that needed improvement, for example staff recruitment and supervision. However, we were unable to locate evidence to determine other elements of the anonymous information, for example specific allegations that named staff members did not have the qualifications and experience for their roles and responsibilities. We did note that there had been an incident when a member of the management team did not adhere by expected professional boundaries, which was investigated a by a local authority safeguarding team. The care workers we spoke with told us they felt supported by the management team, although information from anonymous sources had indicated that this wasn't the case. We looked at the minutes for staff meetings within the past 12 months, which indicated that staff were given clear information about any changes and their achievements were acknowledged and appreciated. There was also an awards system for 'carer of the month', to formally recognise the efforts of employees.

The registered manager understood how to work in partnership with other organisations and we saw detailed examples of how she had promoted the needs of people who use the service to receive assessments and increased support from other organisations. We received notifications of events at the service, as required by legislation.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 Need for consent The provider did not always ensure that they carried out an assessment of people's needs and preferences and designed care to meet these needs and preferences Regulation 9(1)(2)(3)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1) HSCA (RA) Regulations 2014 The provider did not always ensure that care was only provided with the consent of the relevant person Regulation 11(1)